WINDSOR-ESSEX CATHOLIC DISTRICT SCHOOL BOARD

1325 California Avenue
Windsor, ON N9B 3Y6
Telephone: (519) 253-2481

# Pr ST:11 FORM B

## STUDENT HEALTH SUPPORT PLAN
## (CHRONIC AND HIGH RISK MEDICAL CONDITIONS)

***Authorization for the collection of this information is in the Education Act. The purpose is to develop an individualized in-school student health support plan, and, in emergency situations, to administer medication as prescribed and/or obtain medical treatment. Users of this information may be principals, teachers, support staff, volunteers, bus operators and drivers. This form will be kept for a minimum period of one school year and then shredded. Contact person concerning this collection is the school principal.***

| **STUDENT INFORMATION** (*to be completed by Parent(s)/Legal Guardian(s)/Student - if not a minor*) | | | | |
|---|---|---|---|---|
| **Name of Student:** | | | | **STUDENT PHOTOGRAPH** |
| **Birth Date:** (dd/mm/yy) | | **Medic Alert I.D.:** | | |
| **School Name:** | | | | |
| **Home Address:** | | | | |
| **Home Telephone:** | | **Emergency Telephone:** | | |
| **Name of Father:** | | **Business Telephone:** | | |
| **Name of Mother:** | | **Business Telephone:** | | |
| **Name of Legal Guardian:** | | **Business Telephone:** | | |

| **MEDICAL INFORMATION - CHRONIC / HIGH RISK MEDICAL CONDITION** (*to be completed by Family Physician*) | | | |
|---|---|---|---|
| **Chronic/High Risk Medical Condition:** | | | |
| **Possible Signs of Acute Symptoms:** | | | |
| **Recommended Response:** | | | |
| **Medication:** | | **Dosage:** | |
| **Medication:** | | **Dosage:** | |
| **Additional Instructions or Information:** | | | |
| | | | |
| **Name of Physician: (PLEASE PRINT)** | | **Physician's Telephone:** | |
| **Signature of Physician:** | | **Date:** | |

| **STUDENT INFORMATION** (*to be completed by Parent(s)/Legal Guardian(s)/Student - if not a minor)* | | | | |
|---|---|---|---|---|
| **Name of Student:** | | | | |
| **Birth Date:** (dd/mm/yy) | | **Medic Alert I.D.:** | | **Date of Health Support Plan:** |

## PARENT / GUARDIAN COMMITMENTS

**At School**

- ☐ Complete STUDENT HEALTH SUPPORT PLAN in conjunction with Principal or Designate
- ☐ Provide appropriate medication/supplies and consent for administration
- ☐ Provide up-to-date photos if necessary

**On Field Trip/Excursion**

- ☐ Fill out appropriate area on Field Trip/Excursion Information form and provide special instructions

## EMERGENCY ACTION PLAN

(*to be completed by Parent(s)/Legal Guardian(s)/Student (if not a minor) with school personnel input as necessary*)

## IN-SCHOOL STUDENT HEALTH SUPPORT PLAN / DAILY MANAGEMENT PLAN

(*to be completed by Parent(s)/Legal Guardian(s)/Student (if not a minor) with school personnel input as necessary*)

**Note for students with Type 1 diabetes**: An in-school student health support/daily management plan shall be developed so that students can safely manage their diabetes. The following must be adhered to as part of the Plan: while in-school the student has the right to do blood sugar checks in the location the child is in when the need arises; treat hypoglycemia with emergency sugar, inject insulin; eat snacks when necessary at any location inside or outside the building; eat lunch at an appropriate time and have enough time to finish the meal; have free and unrestricted access to water and the bathroom; participate fully in physical education classes, gym classes and other extracurricular activities, including field trips; and other accommodations as necessary to carry out all aspects of his/her daily management in a safe and supportive environment. A blood glucose chart, specific to the student, should be attached to the Plan identifying symptoms and action to be taken at various blood glucose levels.

| **STUDENT INFORMATION** (*to be completed by Parent(s)/Legal Guardian(s)/Student - if not a minor)* | | | | |
|---|---|---|---|---|
| **Name of Student:** | | | | |
| **Birth Date:** (dd/mm/yy) | | **Medic Alert I.D.:** | | **Date of Health Support Plan:** |

## PARENT / GUARDIAN AGREEMENT

I, _____, acknowledge my participation in the development of the preceding Student Health Support Plan and agree to execute reliably the parent/guardian commitments listed within them.

I give my consent for the staff of _____ School to execute the Plan. I understand that this Plan will be reviewed annually (prior to the beginning of each school year) and I will update the school if circumstances change before the review.

I/We acknowledge that it is neither the objective nor purpose of the school to administer medication to students and understand that the school is prepared to undertake this activity as a last resort. In the event of an emergency, I authorize the school staff identified in the Plan to administer the designated medication and obtain suitable medical assistance. I agree to assume responsibility for all costs associated with medical treatment and absolve the Windsor-Essex Catholic District School Board and its employees of responsibility for any adverse reactions resulting from administration of the medication.

I/We the parents/guardians of _____ give permission for this individual Student Health Support Plan to be displayed in the school office, staff room, homeroom, school bus, cafeteria, food service office, and for other parents and concerned individuals to be advised of our child's condition.

| | |
|---|---|
| | |
| **Signature**<br>**Parent/Guardian/Student (if not a minor)** | **Date** |

**School Principal will direct copies to**: Parent, Teacher(s), Student's Ontario Student Record, General Manager of Student Transportation, other staff working directly with the student on a daily basis, and post as appropriate.